

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER:	2. STATE
	13-46	New York
OR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2013	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447.204	7. FEDERAL BUDGET IMPACT: a. FFY 04/01/13-09/30/13 \$0 b. FFY 10/01/13-09/30/14 \$0 ³⁰
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Page 1(e)(1)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B: Page 1(e)(1)

10. SUBJECT OF AMENDMENT:
Extend APG methodology

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Jason A. Helgeson

14. TITLE: Medicaid Director
Department of Health

15. DATE SUBMITTED: April 24, 2013

16. RETURN TO:

New York State Department of Health
Bureau of HCRA Operations & Financial Analysis
99 Washington Ave - One Commerce Plaza
Suite 810
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED	18. DATE APPROVED: JUL 16 2013
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Michael J. Melendez	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health Operations
23. REMARKS: As per the State's request via e-mail on July 16, 2013, a pen & ink change was made to box 7b.	